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"My culture doesn't 100% like these kinds of services, but you decide what to do": Female refugees' experiences with sexual and reproductive healthcare in the Southeastern U.S.

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ABSTRACT

Objective: This study investigates female refugees' experiences accessing and utilizing sexual and reproductive (SRH) services in the state of Georgia.
Methods: We conducted in-person, in-depth semi-structured interviews with 26 female refugee adolescents and adults from Burma, Bhutan or Nepal, and the Democratic Republic of Congo living in Georgia. Questions inquired about perceptions and experiences while accessing and utilizing SRH services. Data were analyzed using thematic analysis.
Results: Participants discussed the importance but also varying influence of social and cultural norms on SRH service utilization. Challenges to accessing and utilizing SRH services included communication and cost barriers. Facilitators included accessible clinic locations, transportation, and positive interactions with clinic providers and staff.
Conclusion: Understanding female refugees' experiences accessing and utilizing SRH services is critical to meet their SRH needs adequately. Through community engagement, practitioners and researchers can gain insights into cultural influences on SRH, address communication and cost barriers, and enhance existing facilitators to increase female refugees' access and use of services.
Innovation: Our community-engaged study incorporated perspectives of diverse groups of refugee women and adolescents in the Southeastern U.S. Findings from this study highlight lived experiences with SRH services and identify barriers to and facilitators of SRH services access and utilization.

1. Introduction

Female refugees have unique sexual and reproductive health (SRH) needs that partly result from their experiences before resettlement in a new country [1-3]. Once resettled in the U.S., these unmet SRH needs may be exacerbated [3-5]. Previous research has found barriers to SRH services access and utilization such as religious or cultural preferences, financial challenges, limited language proficiency, discrimination, and lack of available and high-quality services [4,6].

The state of Georgia has historically resettled diverse U.S. refugee groups [7-9]. However, limited research has elicited emic [10] perspectives from cultural insiders on experiences of SRH services access and utilization in Georgia. To fill this literature gap, we conducted qualitative interviews with female refugee adolescents and adults across communities living in Georgia to explore facilitators of and barriers to services access and utilization.

Our conceptual framework incorporates the Socioecological Framework (SEF) [11] and Penchansky and Thomas' Theory of Access [12]. SEF describes how engagement in SRH services utilization is influenced by factors at multiple levels (e.g., interpersonal, health systems, community) [11]. Theory of Access assessed accessibility, availability, acceptability, affordability, and adequacy [12].

2. Methods

2.1. Population studied and sampling procedures

Eligibility criteria included: 1) self-identifying as female, 2) reproductive age (ages 15–49) [13], 3) having arrived in the U.S. as a

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refugee, and 4) being from Burma, Bhutan or Nepal, or the Democratic Republic of Congo (DRC). These countries were selected because they were among the top countries of origin for refugees in Georgia and the U.S. [7]. The majority of refugees from Bhutan in the U.S. are descendants of Nepali migrants (i.e., Lhotshampas) and may identify as Nepali [14-16].

We recruited participants from July to December 2019 using convenience, snowball, and quota sampling. We first asked community-based organizations (CBOs) serving refugees in Georgia to help recruit for our study. For snowball sampling, enrolled participants assisted us in identifying others who were eligible. Once those women were recruited, they were asked to identify additional potential participants, and this process continued until the target sample size was reached. The sample size was determined based on goals to recruit equal number of refugees from each country of origin and recommendations for saturation [17]. The Emory University Institutional Review Board approved this study.

2.2. Data collection

We conducted in-person, in-depth semi-structured interviews (~45 min long). Female interpreters with similar cultural backgrounds as the participants and trained in research methods facilitated the verbal consent process and conducted interviews in participants' preferred languages (i.e., Burmese, Nepali, or French). For participants under 18, both parental consent and minors' assent was obtained. If participants preferred to conduct the interviews in English, GB or MV conducted the interviews. Each participant received a $20 gift card for compensation. The interview guide (Appendix A) was designed to elicit information reflecting the key domains of the conceptual framework. We inquired about experiences while accessing and utilizing the following SRH services: contraceptive, HPV vaccination, cervical and breast cancer screening, and prenatal care.

2.3. Data analysis

Interviews were transcribed and translated if necessary. We used MAXQDA (VERBI Software, Berlin, Germany) for data management and analysis. Data were analyzed by three coders using thematic analysis, following the six phases outlined by Braun & Clarke [18] (Appendix A).

3. Results

3.1. Participant characteristics

Table 1 shows participant characteristics. The sample consisted of 26 female refugees, including ten from Burma (38.5%), ten from Bhutan/Nepal (38.5%), and six from the DRC (23.1%). The mean age was 28.4 years. They were married (61.5%), had insurance (69.2%), and had an average length of 5.0 years in the U.S.

Table 1
Sociodemographic Characteristics of Women (N = 26).

Variable	N (%) or M (SD)
Age Group	
Adolescent (ages 13-17)	7 (26.9)
Adult (ages 18-49)	19 (73.1)
Age	28.4 (10.1)
Refugee Community	
Bhutanese/Nepali	10 (38.5%)
Congolese	6 (23.1%)
Karen	6 (23.1%)
Chin	3 (11.5%)
Burmese	1 (3.8%)
Number of years in the U.S.	5.0 (3.1)
Marital status	
Married	16 (61.5%)
Never married	9 (34.6%)
Divorced	1 (3.8%)
Employment status	
Employed	9 (34.6%)
Unemployed	17 (65.4%)
Number of children (N = 25)	2.2 (2.0)
Health insurance coverage	
Insured	18 (69.2%)
Uninsured	8 (30.8%)
English fluency	
Not at all	4 (15.4%)
Not well	10 (38.5%)
Well	9 (34.6%)
Very well	3 (11.5%)
Have previously delayed care because of cost	
Yes	5 (19.2%)
No	21 (80.8%)

3.2. Themes

Emerging themes across refugee groups and associated quotes are shown in Table 2 and further described in subsequent sections. Multilevel factors (e.g., health system, interpersonal) and dimensions of access (e.g., accessibility, affordability) from our conceptual framework are described within each of the emerging themes.

3.2.1. The influences of social and cultural norms

Consistent across refugee groups, social and cultural norms related to patient-provider interactions, SRH and service use, and modesty, influenced participants' discussion and use of SRH services in multiple ways. Sometimes, cultural expectations surrounding SRH (e.g., birth control, fertility) impeded participants' choice of SRH services as well as their interactions and comfort with discussing these topics with providers. However, some also stated that the priority of their culture is healthy individuals, or that it is not uncommon to talk about supposedly taboo topics (e.g., STDs) in their culture. Participants acknowledged the varying level of cultural influences and their own agency in making choices about SRH services utilization.

3.2.2. Facilitators to access and utilization of SRH services

3.2.2.1. Accessible clinic locations and transportation. Important characteristics include clinics being within walking distance, access via public transportation, and rides from family members. Several described how this accessibility of clinics also led them to recommend the clinics to others in their community.

3.2.2.2. Positive interactions with providers and staff. Positive interactions included feeling comfortable with providers, having providers who listened to and were responsive to needs and concerns, and having staff and providers who answered questions. This respectful treatment gave participants a sense of security when seeking out SRH services and encouraged further services utilization.

3.2.3. Barriers to access and utilization of SRH services

3.2.3.1. Language or communication barriers. Across communities, participants mentioned challenges in communicating with providers in English. They also discussed how challenges created by interpretation services impacted patient-provider interactions (e.g., interpreters did not adequately communicate their health needs to providers).

3.2.3.2. Financial barriers. Some participants were limited in the type of services they could access (e.g., only access free clinics but not specialist clinics). Relatedly, they also perceived insurance requirements (e.g., income limit) or lack of insurance as financial barriers to services access and utilization.

Table 2
Themes and Selected Quotes.

Themes	Selected Quotes
Social and Cultural Norms Influencing SRH Utilization	
	Bhutanese Participant #09: "Well, before I give birth, I was still (laughs), you know, never had a child, so it's kind of uncomfortable because you don't want to show your private part and don't want to talk about your personal stuff. But yeah, pretty uncomfortable. Yeah (laughs)… It's because, you know, us – I don't know if that's in American culture, but in Asian, particularly Nepali, Bhutanese, like we don't like to show our body, we like to cover."
	Congolese Participant #32: "My culture doesn't 100% like these kinds of services. But again you are the one who can decide what to do. In my culture it's not bad, it is not right, but it is your choice… In my culture they also talk about STDs. These services are respected in my culture."
	Burmese Participant #26: "Both language and culture caused issues for me because in our culture, we rarely discuss about fertility issues with the doctor/provider."
	Congolese Participant #37: "Some regions do not respect birth control and family planning, but [others] do because if you are a woman and you have a lot of children and cannot provide for them that is not good. But some do not respect it because they like to do what their ancestors did and because their ancestors birthed a lot of children, they do the same, so they do not respect birth control."
	Congolese Participant #39: "All cultures, even my culture, wants everyone to be healthy."
Facilitators to access and utilization SRH services	
Accessible clinic locations and transportation	*Congolese Participant #32:* "I do not have any problems going to the clinic because my husband can take me to the clinic or hospital. If it is close to my house I can walk or take the bus…also helps me with transportation and to get to the hospital."
	Burmese Participant #26: "I always recommend this clinic to expecting mothers because the location is close to us and we can always take the bus."
	Burmese Participant #25: "The clinic is very close to where I live and the service was very good. Therefore, I recommend this place to my friends."
Positive interactions with providers and staff	*Congolese Participant #32:* "When I went for the visit, they listened carefully to me. They told me that they would contact me. They really paid attention to what I was talking about. They also directed me."
	Congolese Adult Woman, Participant #37: "I was very comfortable because they protected me and when I am protected I feel comfortable."
Barriers to access and utilization of Sexual and Reproductive Health (SRH) services	
Language or communication barriers	*Bhutanese-Nepali Participant #01:* "For example, [the interpreters] would stop me in the middle of something I say and the provider would say that he/she understood even though they did not. Also, the interpreter would misunderstand my statement and explain something different to the provider."
	Congolese Participant #40: "I do not speak good English, but I can understand better than I can speak. I do not really like interpreters on the phone, because I notice they will say less than what I say or they would add more. Also, sometimes they would say things the doctor doesn't say, which I can pick up on. I don't really like using interpreters, especially on the phone."
Financial barriers	*Burmese Participant #26:* "We can only afford free and cost-effective clinics, in which they often give pain killers. Since we cannot afford specialist clinics, we feel that the health problems we are facing have not been solved yet."
	Congolese Participant #39: "Women have health problems but they can't go to the doctor or hospital because they do not have Medicaid or insurance."
	Bhutanese-Nepali Participant #08: "The thing is, if the person has health insurance, they can seek these (sexual and reproductive health) services. If they do not have health insurance, they can't afford to see a doctor at all and will hide their disease. The health insurance is the problem."
	Burmese Participant #30: "Probably if they had Medicaid, because usually we don't have Medicaid because like apartment bills, so like two parent work together, they both work, so if like two parents work, we don't have Medicaid. So most of the time, they go to the hospital, they'll have to pay for it. So probably like not that much expense on medicines would be good."

4. Discussion and conclusion

4.1. Discussion

Our study provides insight into female refugees' experiences accessing and utilizing SRH services in Georgia. For some, social and cultural norms (e.g., modesty, hesitance in discussing SRH issues, concerns about SRH services use) can impede services access and utilization. For others, despite these norms, they viewed SRH services as a woman's choice, and sought them out regardless. However, others discussed positive impacts of their culture on SRH services utilization and their personal agency in making SRH choices. This discussion points to the multifaceted influences of social and cultural norms, which should be considered when designing culturally-tailored SRH interventions [6]. In addition, results also point to the need to address other modifiable factors: interpersonal (e.g., patient-provider communication), health system (e.g., interpretation services, affordability), and policy factors (e.g., health insurance).

Similar to previous studies, language and communication were barriers in accessing and utilizing SRH care for refugee women [3-5]. Issues included a lack of providers speaking the same language as well as miscommunication resulting from poor interpretation services, which can lead to unmet needs, inadequate services receipt, or misdiagnoses or incorrect treatment [5,19], and deter female refugees from accessing future SRH care. Possible solutions include asking interpreters if clarification is needed, ensuring patient's responses are being interpreted fully, and confirming that patient's concerns or questions have been addressed [20]. Careful attention to interpretation can also make female refugees feel more positive about their treatment by providers, a noted facilitator of SRH services utilization. Additionally, cost emerged as a barrier, partly due to a lack of insurance coverage. A possible solution is to connect patients with local free or low-cost services that can help meet SRH needs.

Accessible clinic locations and respectful treatment from clinic providers not only increased participants' own use of services but may also lead to them recommending services to community members. Future programs should consider transportation services/vouchers to make clinics more accessible as well as targeted training for providers [21-23]. Providers can consider establishing relationships with CBOs serving refugee populations, which can facilitate understanding diverse beliefs and norms of refugee communities and providing culturally-informed SRH services [21,22].

While our findings provide key insights into female refugees' experiences, given the heterogeneity of experiences, the transferability of results to different settings and contexts may be limited [24]. Our study was conducted in Georgia, with participants' average length of time in the U.S. being five years. Findings may not be applicable to those who are in different U.S. contexts or have been in the U.S. for shorter or longer periods. Future research can explore SRH service access and use longitudinally and in different U.S. settings.

4.2. Innovation

Our innovative study seeks to shift current SRH delivery for female refugees. Our study was guided by a multilevel conceptual framework developed through integrating theories in behavioral sciences and health services research [11,12], which helps identifying concepts that map onto theoretical constructs and examining multilevel determinants. Sampling refugee adolescents and adults from understudied groups helps identify

commonalities through distinct life stages and in different communities. Furthermore, our setting is the Southeastern U.S., where SRH care and access is relatively more restrictive compared to other regions of the country [25]. Additionally, we employed a community-engaged approach throughout all project aspects, from the design and implementation of the study to interpretation and publication of findings, where we utilized engaged participation from community members throughout the process [26].

4.3. Conclusion

Findings from this study fill gaps of knowledge on female refugees' SRH in the Southeast to better inform and deliver SRH services. In addition to identifying existing barriers, the study highlighted opportunities and resources to help practitioners and researchers better deliver SRH services to female refugees to meet their unique needs.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.pecinn.2023.100172.

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